

CLIENT INTAKE FORM

Client Reference # _____ Mail form to: _____
 Date: _____ Would you like to receive our newsletter? _____
 Name (please print): _____ Cell Phone: () _____
 Address: _____ Home Phone: () _____
 City: _____ County _____ Work Phone: () _____
 State: _____ Zip: _____ Email: _____ May we contact you at home? Yes / No
 When is a good time to contact you? _____ Leave a message? Yes / No Texting? Yes / No
 Emergency Contact Person: _____ Phone #: _____

Check appropriate boxes

AGE	FAMILY STATUS	CHILDREN	AVAILABLE FOR COUNSELING	
			DAY	TIME
<input type="checkbox"/> Under 20	<input type="checkbox"/> Married	<input type="checkbox"/> Living at home	<input type="checkbox"/> M	_____ to _____
<input type="checkbox"/> 20-29	<input type="checkbox"/> Single	<input type="checkbox"/> Grown; living elsewhere	<input type="checkbox"/> T	_____ to _____
<input type="checkbox"/> 30-39	<input type="checkbox"/> Divorced	<input type="checkbox"/> Other (please explain)	<input type="checkbox"/> W	_____ to _____
<input type="checkbox"/> 40-49	<input type="checkbox"/> Separated	_____	<input type="checkbox"/> Th	_____ to _____
<input type="checkbox"/> 50-59	<input type="checkbox"/> Widowed	_____	<input type="checkbox"/> F	_____ to _____
<input type="checkbox"/> 60+				

TYPES OF CRISIS				
<input type="checkbox"/> abuse - sexual	<input type="checkbox"/> depression	<input type="checkbox"/> spouse	<input type="checkbox"/> promiscuity	<input type="checkbox"/> spirituality
<input type="checkbox"/> abuse - physical	<input type="checkbox"/> divorce	<input type="checkbox"/> illness/disability	<input type="checkbox"/> relationships	<input type="checkbox"/> suicide
<input type="checkbox"/> alcohol/drugs	<input type="checkbox"/> eating disorders	<input type="checkbox"/> jail	<input type="checkbox"/> self-esteem	<input type="checkbox"/> woundedness
<input type="checkbox"/> childlessness	<input type="checkbox"/> fears/phobias	<input type="checkbox"/> parenting	<input type="checkbox"/> sexuality	_____ from childhood
<input type="checkbox"/> death	<input type="checkbox"/> financial	<input type="checkbox"/> pregnancy	<input type="checkbox"/> singleness	

*If possible, please prioritize your crises (1, 2, 3, etc.). What issue is most pressing at this time? _____

Are you employed outside the home? _____ Where? _____

Church affiliation: _____

How did you find out about this ministry? Newspaper: _____ Radio: _____ Brochure: _____ Church: _____

Friend: _____ Professional referral: _____ Website: _____ Social Media: _____ Other: _____

Please name the referral: _____

Have you had counseling before? _____ Where? _____

Please list any medications you are currently taking. _____

Do you have any medical conditions that your peer counseling volunteer should be aware of as you come for counseling? (i.e. seizures, diabetes, allergies) Please list. _____

Thank you for being here. Your presence here is a confirmation that this ministry is needed.

It is our prayer that you will receive a measure of peace about your situation as you share your story with one of our counseling volunteers. We want you to feel comfortable as you share with this partner, knowing that anything you say will be held in confidence. We have made every effort to connect you with someone who has been through a similar situation as you have, and has experienced healing through Christ.

Our counseling volunteers are not professionals and should not be a substitute for professional psychological, psychiatric or medical care. We are here to share with you and support you with scripture and prayer.

Please sign here indicating you have read the above and realize our limitations:

Signed: _____

Please summarize the need that brings you here, continue on back if necessary.

If you could use only one word to describe your feelings about your situation at this point, what would it be?